Application for Self- Insurance

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U.S. Department of Labor

Office of Workers' Compensation Programs
https://www.dol.gov/agencies/owcp/dlhwc

OMB No. 1240-0014
Expires: 11/30/2026

The applicant hereby requests that the Office of Workers' Compensation Programs grant permission for the Applicant to become a self- insured employer in accordance with Section 32(a)(2) of the Longshore and Harbor Workers' Compensation Act (33 USC 932 (a)(2)) in regard to the employer's obligations under the Compensation Act checked in item 1. No authorization for self-insurance will be approved unless a completed application form has been received. [33 USC 932 (a)] [20 CFR 703.302]

The declarations made in this application are for the purpose of enabling the Office of Workers' Compensation Programs to make a finding of facts as to whether the Applicant possesses sufficient ability to render certain the payment of compensation, the furnishing of medical services and supplies to injured employees, and the payment of compensation for death in accordance with the provisions of the Act checked in item 1.

The Applicant agrees to make and maintain a deposit of an indemnity bond with the Office **OR** a deposit of securities with a Federal Reserve Bank (option to be indicated in Item 6) which shall be an amount determined by the Office and subject to the order of the Office. The Applicant further agrees to abide by all the rules and regulations administered by the Office pertaining to the Longshore and Harbor Workers' Compensation Act (33 USC 901) or any of the extensions of the Act checked in item 1.

INSTRUCTIONS: All items are to be completed. If the answer to any item requires more space than provided, please attach a separate sheet and identify the item you are answering. Information contained herein shall not be open to public inspection.

The Application must be accompanied by: (1) Copies of certified financial statements for the last three years. (2) Copy of the excess loss coverage contract showing amount of net retention for any one accident and amount of maximum limit, (3) Loss information under the Act for the last five years, showing the amount of paid and reserved losses. This should be in the form of a letter from the insurance carrier(s), showing the loss information for each year, and (4) Statement showing amount of annual payroll under the Act by insurance classification.

The application must be submitted to: U.S. Department of Labor, Office of Workers' Compensation Programs, DLHWC electronically as prescribed by OWCP (20 C.F.R. 703.2(a)) at Longshore_Self-Insured_Communication@dol.gov

1. Check only one of the Acts. If you wish to be self-insured under more than once Act, file a **separate** application for each.

A. ☐ Longshore and Harbor Workers' Compensation Act (33 USC 901)
B. ☐ Nonappropriated Fund Instrumentalities Act (5 USC 8171)
C. ☐ Defense Base Act (42 USC 1651)
D. ☐ Outer Continental Shelf Lands Act (43 USC 1331)

2. Name and Address (principal office) of Applicant

EIN:

name

addr1 city country

addr2 state zip United States

3. NATURE OF BUSINESS - Describe briefly the general character of the operations performed and work done. If more than one class of work is conducted, indicate division in payroll of each. Description should relate only to operations performed and work done under the Act checked in item 1. Omit operations performed and work done under the State Compensation Act.

4. Information appearing in the columns below should relate to employees governed by the act checked in item 1 and for which self-insurance authorization is requested. Omit employees governed by the State Workers' Compensation Act. If you cannot so separate your employees between the act checked in item 1 and the State Act, give information relating to all employees and indicate that the data covers all your employees.

Work Places and Locations a	Estimated Number of Employees b

5. If you are now authorized as a self- insurer under any state workers' compensation program, give amounts of indemnity bonds and securities, and the states in which deposited.

a. State	b. Amount of Indemnity Bond	c. Amount of Securities

6. If this application is granted, which do you elect to deposit under this act?

☐ Indemnity Bond
☐ Securities
☐ Letter of Credit

7. Do you maintain a medical facility for the care of injured employees?

☐ Yes (Describe equipment and service)

☐ No (Specify arrangements you have made)

8. Which do you intend to do?	(If you have checked "a", give name and address of persons responsible for claims handling, with brief resume of their experience. If you have checked "b", give name and address of the organization, and describe the arrangements, including what, if any, experience the organization has in Longshore.)
a. ☐ Deal directly with employees in compensation matters	
b. ☐ Deal through an insurance service organization	

9. ACCIDENT EXPERIENCE FOR PREVIOUS YEARS

YEAR	20	20	20
a. Number of deaths			
b. Number of permanent total disability cases			
c. Number of permanent partial disability cases (Schedule losses only)			
d. Number of injuries not included in a, b, and c above, causing disability more than three days			
TOTALS			

10. Date of incorporation (mm/dd/yyyy)	11. Incorporated under laws of what state?	12. Date applicant was established (if not a corporation) (mm/dd/yyyy)

13. Did you succeed anyone? (If "Yes", state whom)

☐ Yes ☐ No

14. Name of President	15. Name of Vice President
16. Name of Treasurer	17. Name of Secretary

18. I certify that I am an official of the above named applicant, duly authorized to file this application, that I have carefully examined the foregoing statements, and the facts herein are true.

_____ (SEAL)

Signature Telephone

19. Name and Title	20. Date of this application (mm/dd/yyyy)

DO NOT WRITE IN THE ITEMS BELOW

21. Date application received	22. OWCP Certification

PRIVACY ACT STATEMENT

The Privacy Act of 1974 as amended (5 U.S.C. 522a), section 901 of Title 33 to the US Code and 33 U.S.C. 932 (a) authorize collection of this information. The purpose of this information is to determine an applicant's qualifications as a self-insurer under the Longshore and Harbor Workers' Compensation Act (LWHCA). Completion of this form is not mandatory; however, failure to provide the information may result in the denial of request to self insure. Additional disclosures of this information may be to: (1) the employer which employed the claimant at the time of injury, or to the insurance carrier or other entity which secured the employer's compensation liability. (2) physicians and other medical service providers for use in providing treatment or medical/vocational rehabilitation, making evaluations and for other purposes relating to the medical management of the claim. (3) the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matter arising in connection with the claim. (4) Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the LHWCA to determine whether benefits are being and have been paid properly, and where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law. (5) Failure to disclose all requested information may delay the processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 3 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. Send comments regarding this burden estimate or any aspect of this collection of information, including suggestions for the reducing of this burden, to the U.S. Department of Labor, 200 Constitution Avenue, NW, Room S-3524, Washington, D.C. 20210 and reference the OMB Control Number.